

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-041061

STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 590 Registrar's No. 3154

DO NOT WRITE
ON THIS STUB

AMENDED

VS 300
Rev. 4/59

1 4042

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DATE AMENDED

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Valley Park</u> c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Valley Pk. Nursing Home</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>St. Louis</u> c. CITY OR TOWN <u>Webster Groves</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) <u>400 Algonquin Place</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>SARAH JANE KENNEDY</u>		4. DATE OF DEATH Month Day Year <u>Oct. 30, 1962</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>1-29-73</u>
9. AGE (last birthday) <u>89</u>		IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At home</u>	
11. BIRTHPLACE (City and state or country) <u>Shippensburg, Penn.</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13a. FATHER'S NAME <u>Unknown</u>		13b. MOTHER'S MAIDEN NAME <u>Unknown</u>	
14. NAME OF HUSBAND OR WIFE <u>James L. Kennedy</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Jas. H. Kennedy, 400 Algonquin Pl.</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>5 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year			
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION	COUNTY STATE
21. I attended the deceased from <u>June 4, 1961</u> to <u>Oct. 30, 1962</u> and last saw her alive on <u>Oct. 25, 1962</u> Death occurred at <u>3:50 A</u> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>Robert S. Sanders, M.D.</u> (Degree or title)		22b. ADDRESS <u>1502 Cass St</u>	22c. DATE SIGNED <u>10.30.62</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>10-31-62</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Fairview Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Mishawaka, Indiana</u>
24. FUNERAL DIRECTOR <u>Parker-Aldrich, Webster Groves</u> ADDRESS		25. DATE RECD. BY LOCAL REG. <u>10-30-62</u>	26. REGISTRAR'S SIGNATURE <u>J. B. Murphy, M.D.</u>

(Licensed Embalmer's Statement on Reverse Side)

-USE BLACK INK
OR
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed _____

Leslie Nelson

Licensed Embalmer No. 1395

P. O. Address Wester Grove Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.